Washington Dental Service

Benefits Booklet

City of Seattle

I. B. E. W. - Local 77

Effective January 1, 2010
and 2011 Updates

Delta Dental Premier®

City of Seattle Policy #5
Local 77

Washington Dental Service
Plan **#00160**

Effective **January 1, 2010**

Questions Regarding Your Plan

If you have questions regarding your dental benefits plan, you may call:

Washington Dental Service Customer Service

(206) 522-2300
(800) 554-1907

Written inquiries may be sent to:

Washington Dental Service
Customer Service Department
P.O. Box 75983
Seattle, WA 98175-0983

You can also reach us through Internet e-mail at *info@DeltaDentalWA.com*.

For the most current listing of Washington Dental Service participating dentists, visit our online directory at *www.DeltaDentalWA*.com.

Communication Access for Individuals who are Deaf, Hard of Hearing, Deaf-blind or Speech-disabled

Communications with Washington Dental Service for people who are deaf, hard of hearing, deaf-blind and/or speech disabled is available through Washington Relay Service. This is a free telecommunications relay service provided by the Washington State Office of the Deaf and Hard of Hearing.

The relay service allows individuals who use a Teletypewriter (TTY) to communicate with Washington Dental Service through specially trained communications assistants.

Anyone wishing to use Washington Relay Service can simply dial 711 (the statewide telephone relay number) *or* 1-800-833-6384 to connect with a communications assistant. Ask the communications assistant to dial Washington Dental Service Customer Service at 1-800-554-1907. The communications assistant will then relay the conversation between you and the Washington Dental Service customer service representative.

This service is free of charge in local calling areas. Calls can be made anywhere in the world, 24 hours a day, 365 days a year, with no restrictions on the number, length or type of calls. All calls are confidential, and no records of any conversation are maintained.

Well Baby Checkups

For your infant child, Washington Dental Service offers access to oral evaluation and fluoride through your family physician. Please ensure your infant child is enrolled in your dental plan to receive these benefits. Many physicians are trained to offer these evaluations, so please inquire when scheduling an appointment to be sure your physician offers this type of services. When visiting a participating physician with your infant (age 0-3), WDS will reimburse the physician on your behalf for specific services performed, up to the amount listed below:

- Oral Evaluation: Reimbursed up to $43
- Topical application of fluoride: Reimbursed up to $36

Please see the "Benefits Covered by Your Plan" section of this booklet for any other limitations. Also, Please be aware that Washington Dental Service has no control over the charges or billing practices of non-dentist providers which may affect the amount Washington Dental Service will pay and your financial responsibility.

City of Seattle

Dental Program
#00160 – Policy 5

Inside ...

To All Eligible Employees:

This booklet describes the Group Dental Program available to employees and dependents of the City of Seattle. Currently the City pays all or a major portion of the costs of the plan for eligible employees and their dependents. Employees may be required to contribute to the plan on a cost-sharing basis or may not be eligible for certain benefits in accordance with collective bargaining agreements.

The Washington Dental Service Incentive Plan described in this booklet is designed to encourage you and your dependents to utilize the services of a dentist each year. Through such usage you receive greater benefits.

You are urged to have regular checkups and preventive treatment to promote continuing dental health for yourself and your family.

Summary of the Program

Who Is Covered?

All eligible employees and their eligible dependents are covered.

What Is Covered?

Your program provides basic dental care necessary for good dental health. It does not allow all procedures. If you desire care not covered by your program, you must arrange this between yourself and your dentist. The basic program will assist you in meeting additional costs through payment of the basic cost.

How Do I Apply?

An application form must be completed by you and returned to your Department Human Resources or Payroll Representative. All eligible family members are to be listed on the application form.

Whenever a change occurs in the number of dependents becoming eligible or ineligible, or if your name changes, a revised application form listing current dependents, or the name change, should always be submitted to your Department Human Resources or Payroll Representative.

Can I Choose My Own Dentist?

Yes, you may select any licensed dentist. Charges for dental services performed by a dental mechanic or any other type of dental technician who is not a licensed dentist are not covered.

What If My Dentist Is A Delta Dental Participating Dentist?

WDS is comprised of Delta Dental Participating Dentists who agree to file their fees and perform services in accordance with conditions set forth in a written agreement entered into by the dentist and WDS. Delta Dental Participating Dentists will submit claims for you and receive payment directly from WDS. You are responsible for any portion of the bill remaining.

What If My Dentist Is A Nonparticipating Dentist?

If you select a dentist who is not a Delta Dental Participating Dentist of Washington Dental Service, you are responsible for having your dentist complete and sign a claim form. We accept any American Dental Association-approved claim form that your dentist may provide. It is up to you to ensure that the claim is sent to Washington Dental Service. Since Washington Dental Service does not have fees on file for Nonparticipating Dentists, the payment for services performed by a nonparticipating dentist is based upon actual charges or Washington Dental Service's allowable fees for Nonparticipating Dentists, whichever is less. The payment will be issued in both your name and that of your dentist unless you specifically authorize that payment be made directly to your dentist.

Can I Receive Dental Care Outside The State of Washington?

If you receive treatment from a dentist outside Washington State, you are responsible for having the dentist complete and sign a claim form. It is up to you to pay the dentist's bill and submit the claim to Washington Dental Service. Payment will be based upon actual charges or Washington Dental Service's maximum allowable fees for out of state dentists, whichever is less.

Where May I Obtain Claim Forms?

You may obtain claim forms from your Department Human Resources or Payroll Representative or WDS. WDS will not be obligated to pay for treatment performed in the event claim forms are submitted for payment more than 12 months after the date of completion of treatment. Orthodontic claims must be submitted within 12 months of the initial banding date.

Is There A Program Maximum?

Yes. The maximum amount payable by WDS for Class I, II & III Covered Dental Benefits for each eligible person is $2,000 per calendar year (January 1 through December 31). Charges for dental procedures requiring multiple treatment dates shall be considered incurred on the date the service is completed. Amounts paid for such procedures will be applied to the program maximum based on such incurred date.

Orthodontic benefits for an eligible child are limited to a $1,500 lifetime maximum and such benefits are in addition to the $2,000 calendar year maximum.

Is There A Program Deductible?

No.

Is A Predetermination of Benefits Required?

A predetermination of benefits is a service that is offered and is very beneficial; however, it is not mandatory. It is strongly suggested that an orthodontic treatment plan be submitted to, and a predetermination be made by, WDS prior to commencement of treatment. A predetermination is not a guarantee of payment. Additionally, payment for orthodontic benefits is based upon your eligibility. If you become ineligible prior to the secondary payment of benefits, the secondary payment is not covered.

If Your Dental Care Will Be Extensive, Ask Your Dentist To Complete And Submit A Standard WDS Claim Form For Predetermination.

This will allow you to know in advance exactly what procedures are covered, the amount WDS will pay toward the treatment and your financial responsibility. A predetermination is not a guarantee of payment.

Is A Second Opinion Required?

WDS may require a patient to obtain a second opinion from a WDS appointed dental consultant for certain treatment, except emergency care. WDS will pay 100 percent of the consultant's charges for the second opinion.

Coordination of Benefits

If an eligible person is entitled to benefits under two or more group dental plans, the amount payable under this plan will be coordinated with any other plan. The amount paid by WDS, together with amounts from other group plans, will not exceed the total of the highest allowable dental expenses incurred.

The following rules establish the order of benefit payments:

a. The benefits of the plan that does not have a coordination of benefits (COB) provision will be primary (the plan whose benefits are determined first).

b. The benefits of the plan that covers the person as an employee, member, policyholder, subscriber or retiree will be determined before the benefits of a plan that covers the person as a dependent.

c. If the person is a child whose parents are not separated or divorced:

   The benefits of the plan covering the parent whose month and day of birth occurs earlier in the calendar year will be determined before the benefits of the plan of the parent whose month and day of birth occurs later in the calendar year. If both parents have the same birthday, the Plan that has covered the parent the longest is the primary Plan.

d. If the person is a child of parents who are separated or divorced or not living together, whether or not they have ever been married, if there is no court decree allocating responsibility for the child's health care expenses or health care coverage, then the benefits are determined in the following order:

   1) The plan covering the custodial parent, first;
   2) The plan covering the spouse of the custodial parent, second;
   3) The plan covering the non-custodial parent, third; and
   4) The plan covering the spouse of the non-custodial parent, last.

e. If a court decrees that one parent has financial or health care expenses or health care coverage responsibility, that plan is primary.

f. The plan covering the person as a retired or laid-off employee or dependent of such person will be determined after the benefits of any other plan covering such person as an employee, other than a laid-off or retired employee, or dependent of such person. This provision will not apply if neither plan has a provision regarding laid-off or retired employees that results in each plan determining its benefits after the other.

g. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan.

h. If the above order does not establish the primary plan, then the plan that has covered that person for the longest period of time is the primary plan.

If you are covered by more than one health plan, you or your provider should file all your claims with each plan at the same time. If Medicare is your primary plan, Medicare may submit your claims to your secondary carrier for you.

If you are covered by more than one health benefit plan, and you do not know which your primary plan is, you or your provider should contact any one of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan to determine which is primary and will let you know within 30 calendar days.

To avoid delays in claims processing, if you are covered by more than one plan you should promptly report to your providers and plans any changes in your coverage.

Note: All health plans have timely claim filing requirements. If you or your provider fails to submit your claim to a secondary health plan within the plan's claim filing time limit, the plan can deny the claim. If you experience delays in the processing of your claim by the primary health plan, you or your provider will need to submit your claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim.

If payments that should have been made under this plan are made by another plan, WDS has the right, at its discretion, to remit to the other plan the amount it determines appropriate. To the extent of such payments, WDS is fully discharged from liability under this plan.

In the event WDS makes payments in excess of the maximum amount, WDS shall have the right to recover the excess payments from the patient, the subscriber, the provider or the other plan.

MySmile® Personal Benefits Center

The MySmile® personal benefits center, available on Washington Dental Service's Web site at www.DeltaDentalWA.com, is customized to your individual needs and provides you with the answers to your most pressing questions about your dental coverage. A simple, task-oriented, self-service interface, MySmile lets you search for a dentist in your plan network, review your recent dental activity, check details of your plan coverage, view and print your ID card, check the status of current claims, and more.

Health Insurance Portability and Accountability Act (HIPAA)

Washington Dental Service is committed to protecting the privacy of your dental health information.

The Health Insurance Portability and Accountability Act (HIPAA) requires WDS to alert you of the availability of our Notice of Privacy Practices (NPP), which you may view and print by visiting www.deltadentalwa.com. You may also request a printed copy by calling the WDS privacy hotline at (206) 985-5963.

Children's Health Insurance Plan Reauthorization Act (CHIPRA)

CHIPRA allows special enrollment rights and allows states to subsidize premiums for employer-provided group health coverage for eligible children (excluding benefits provided under health FSAs and high-deductible health plans).

- Employees and dependents that are eligible but not enrolled for coverage may enroll under the following conditions:
- An employee or dependent loses Medicaid or CHIP coverage due to loss of eligibility, and the employee requests coverage within 60 days after the termination.
- An employee or dependent becomes eligible for a premium assistance subsidy under Medicaid of CHIP and the employee requests coverage within 60 days after the termination.

Contact your employer for further clarification and details of how they plan to implement this coverage for eligible persons.

Uniformed Services Employment & Re-Employment Rights Act (USERRA)

Employees called to military service have the right to continue dental coverage for up to 24 months by paying the monthly premiums, even if they are employed by groups that are too small to comply with COBRA. USERRA contains other employment-related requirements, including (but not limited to) the employer having to hold the employee's position until he/she returns from service. For further information on this act, please contact your legal counsel or insurance producer.

Conversion Option

If your dental coverage stops because your employment or eligibility ends or the group policy ends, you may apply directly to WDS to convert your coverage to an individual policy. You must apply within 31 days after termination of your group coverage. The benefits and premium costs may be different from those available under your current plan. There may be a gap in coverage between the date your coverage under your current plan ends and the date that coverage begins under an individual policy.
You may apply for coverage under a WDS Individual Plan online at www.DeltaDentalWA.com/Individual or by calling (800) 286-1885 to have an application sent to you. Converted policies are subject to certain benefits and limits.

American Recovery and Reinvestment Act (ARRA)

The American Recovery and Reinvestment Act of 2009 (ARRA) provides for premium reductions and additional election opportunities for health benefits under COBRA. The premium reduction applies to periods of health coverage beginning on or after February 17, 2009 and lasts for up to nine months for those eligible for COBRA due to an involuntary termination of employment during the period beginning September 1, 2008 and ending December 31, 2009.

If Both Husband and Wife are Covered by WDS, either as City Employees or by Different Employers, What is the Calendar Year Maximum?

In such instances the calendar year maximum for each of the employees and for an eligible dependent of both employees will equal the total of the maximum(s) specified in each of the two plans.

In either of the situations above, the amount paid by WDS, together with amounts from other group programs, will not exceed 100 percent of dental expenses incurred; and the total amount payable by WDS will not exceed the amount which would have been paid for covered benefits if there were not other programs involved.

Employee Eligibility

You are in an Eligible Class if you: (a) work at least 80 hours per month and are an active, regular full-time employee or a temporary employee in a benefits-eligible assignment and work at least 80 hours per month, or (b) are a temporary employee who is not in a benefits-eligible assignment, but have worked at least 1,040 cumulative non-overtime hours and at least 800 non-overtime hours in the previous 12 month period. You must not be represented by a bargaining group for which a separate Summary of Coverage is available. Your Employer will provide you with this information.

Your Eligibility Date is the effective date of this Plan if you were a regular employee in an Eligible Class on the date the Plan became effective. Otherwise, coverage begins for you and your dependents on your first day of employment if that date is: (a) the first calendar day of the month designated as a City business day, or (b) the first calendar day of the month designated/recognized as the first working day for the shift to which you are assigned, whichever is later. If your employment begins after said date, your coverage will begin the following month.

Your Eligibility Date if you are a temporary employee in an Eligible Class but not in a benefits-eligible assignment, is the first day of the calendar month following the date application is made and the rate is paid, or the date designated by your Employer if application is made during an open enrollment period. If you are a temporary employee in a benefits-eligible assignment, your coverage begins the first calendar day of the month designated as a City business day. If your employment begins after said date, your coverage will begin the following month.

An employee for whom coverage already became effective, but who is absent without pay on the first day of the calendar month and returns by the 15th of the month will not have a lapse in coverage. Coverage for an employee who returns after the 15th of the month will begin the first day of the following calendar month. However, an employee who is absent without pay for 15 consecutive calendar days or less will not have a lapse in coverage.

Continuation of Coverage

Employees on paid sick leave or vacation or on an approved leave of absence of 15 days or less shall be eligible for City-paid contributions for coverage for themselves and eligible dependents for the period away from work.

Employees on an approved unpaid leave of absence for more than 15 days and a return date scheduled for after the 15th of a month may pay for coverage through the provisions of COBRA. Check with your Department Human Resources or Payroll Representative to obtain further information on self-payment procedures.

Employees returning from an approved unpaid leave of absence during which City paid contributions were not provided will have coverage restored according to their return date: (a) return on the 1st through the 15th, coverage is effective the first of that month; and (b) return the 16th to the end of the month, coverage is not effective until the first of the following month.

Termination of Coverage

Coverage terminates at the end of the month in which you lose eligibility. If a dependent is no longer eligible, coverage will terminate at the end of the month during which eligibility ceased. However, you and/or your dependent may be eligible for an extension of group benefits. See the "Extension of Coverage" section and contact your Department Human Resources or Payroll Representative for additional information.

Coverage for Temporary Employees

Temporary employees may in certain circumstances be eligible to participate in this plan on a self-pay basis. A temporary employee who a) is in a benefits-eligible assignment, and works at least 80 hours per month is eligible to obtain City-paid contributions for coverage or b) has worked at least 1,040 hours cumulative non-overtime hours and at least 800 non-overtime hours in the previous 12-month period is eligible to purchase dental benefits.

Enrollment for temporary employees begins the first of the calendar month following the date application is made and the rate is paid, or the date designated by the Group if application is made during an open enrollment period. Enrollment for eligible temporary employees in a benefits-eligible assignment will begin the first calendar day of the month designated as a City business day. If employment begins after said date, the coverage for the temporary employee in a benefits eligible assignment will begin the following month. See your Department Human Resources or Payroll Representative for further information.

Family and Medical Leave

The City of Seattle Family and Medical Leave Ordinance, enacted to comply with the federal Family and Medical Leave Act of 1993, provides up to 90 calendar days of unpaid leave in a 12-month period to eligible permanent employees who have worked at least six months. Leave must be granted for any of the following reasons:

- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse/domestic partner, or a child or parent of the employee or spouse/domestic partner, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Eligible employees and their covered dependents may continue coverage under this plan. Please contact your Department Human Resources or Payroll Representative for more detailed information on Family and Medical Leave.

Dependent Eligibility

Eligible Dependents include:

- The employee's legal spouse or domestic partner named on the Affidavit of Marriage/Domestic Partnership on file with the City.
- Unmarried natural, adopted, legally placed ward or stepchild from birth through 24.
- In the case of divorced parents, unmarried children are eligible and may be enrolled by the parent (an eligible employee) who is legally responsible for health care benefits, regardless of whether or not the child is primarily dependent upon the employee for support. The child shall be eligible from birth through 24.

A child will be considered an eligible dependent as an adopted child if the following conditions are met: 1) the child has been placed with the eligible employee for the purpose of adoption under the laws of the state in which the employee resides; and 2) the employee has assumed a legal obligation for total or partial support of the child in anticipation of adoption. When additional Premium is not required, we encourage enrollment as soon as possible to prevent delays in claims processing (see "Special Enrollment").

Coverage for an unmarried dependent child over the limiting age will not be terminated if the child is and continues to be both 1) incapable of self sustaining employment by reasons of developmental disability (including mental retardation, cerebral palsy, epilepsy, autism, or another neurological condition closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals) or physical handicap and 2) chiefly dependent upon the eligible employee for support and maintenance, provided proof of incapacity and dependency is furnished to WDS within 31 days of the child's attainment of the limiting age and the child was an eligible dependent upon attainment of the limiting age. WDS reserves the right to periodically verify the disability and dependency but not more frequently than annually after the first two years.

Pursuant to the terms of a Qualified Medical Child Support Order (QMCSO), the plan also provides coverage for a child, even if the parent does not have legal custody of the child or the child is not dependent on the parent for support. This applies regardless of any enrollment season restrictions that might otherwise exist for dependent coverage. If parent is not enrolled in dental benefits, he/she must enroll for coverage for himself/herself and the child. If the plan receives a valid QMCSO and the parent does not enroll the dependent child, the custodial parent or state agency may do so.

A QMCSO may be either a National Medical Child Support Notice issued by a state child support agency or an order or judgment from a state court or administrative body directing the company to cover a child under the plan. Federal law provides that a QMCSO must meet certain form and content requirements to be valid. A custodial parent, a state agency or an alternate recipient may enroll a dependent child under the terms of a valid QMCSO. A child who is eligible for coverage through a QMCSO may not enroll dependents for coverage under the plan.

Dependent coverage terminates at the end of the month in which the parent's coverage terminates, or when the dependent ceases to be eligible, whichever occurs first.

You may terminate coverage of an eligible dependent only coincident with a subsequent renewal or extension of the dental plan. Once an eligible employee terminates such eligible dependents coverage, the coverage cannot be reinstated, unless there is a change in family status.

A new family member, with the exception of newborns and adopted children, must be enrolled on the first day of the month following the date he or she qualifies as an eligible dependent. When additional Premium is not required, we encourage enrollment as soon as possible to prevent delays in claims processing (see "Special Enrollment").

A newborn shall be covered from and after the moment of birth, and an adopted child shall be covered from the date of assumption of a legal obligation for total or partial support. When additional Premium is not required, we encourage enrollment as soon as possible to prevent delays in claims processing (see "Special Enrollment") but coverage will be provided in any event. Dental coverage provided shall include, but is not limited to, coverage for congenital anomalies of infant children.

Eligible employees who choose not to enroll an eligible dependent during the initial enrollment period of the dental plan may enroll the eligible dependent only during an open enrollment, except under special enrollment.

Special Enrollment Periods

Special enrollments are allowed under the following conditions:

1. **Loss of Other Coverage**

   If you and/or your eligible dependents involuntarily lose coverage under another dental plan, you may apply for coverage under this Plan if the following applies:

   - You declined enrollment in this Plan.
   - You lose eligibility in another health plan or your coverage is terminated due to the following:
     - Legal separation or divorce.
     - Cessation of dependent status.
     - Death of Employee.
     - Termination of employment or employer contributions.
     - Reduction in hours.
     - Loss of individual or group market coverage because of move from plan area or termination of benefit plan.
     - Exhaustion of COBRA coverage.
   - Your application to enroll in this Plan is received by WDS within 31 days of losing other coverage. Coverage will be effective the first day of the month following receipt of application.

   If these conditions are not met, you must wait until the next Open Enrollment Period to apply for coverage.

   Note: When additional Premium is not required, we encourage enrollment as soon as possible to prevent delays in claims processing.

   Note: Eligible dependents may not enroll in this Plan unless the Employee is a Subscriber.

2. **Marriage, Birth or Adoption**

If you declined enrollment in this Plan, you may apply for coverage for yourself and your eligible dependents in the event of marriage, birth of a child(ren), or when you or your spouse assume legal obligation for total or partial support of a child(ren) in anticipation of adoption.

- Marriage — WDS requests the application for coverage be made within 31 days of the date of marriage. If an additional Premium for coverage is required and enrollment and payment is not completed within the 31 days, the eligible dependent may be enrolled during the next open enrollment.
- Birth — A newborn shall be covered from and after the moment of birth. WDS requests the application for coverage be made within: 60 days of the date of birth. If an additional premium for coverage is required and enrollment and payment is not completed within the 60 days, the eligible dependent may be enrolled during the next open enrollment, but coverage will be provided in any event.
- Adoption — WDS requests the application for coverage be made within 60 days of the date of assumption of a legal obligation for total or partial support of the child in anticipation of adoption. If an additional premium for coverage is required and enrollment and payment is not completed within the 60 days, the eligible dependent may be enrolled during the next open enrollment.

Extension of Benefits

In the event a person ceases to be eligible, or in the event of termination of this Plan, WDS shall not be required to pay for services beyond the termination date. The exception will be for the completion (within three weeks) of procedures requiring multiple visits to complete the work started while coverage was in effect and that are otherwise benefits under the terms of this plan.

How to Report Suspicion of Fraud

If you suspect a dental provider, an insurance producer or individual may be committing insurance fraud, please contact the WDS hotline for Fraud & Abuse at (800) 211-0359 or (206) 985-5927. You may also want to alert any of the appropriate law enforcement authorities listed:

- The National Insurance Crime Bureau (NICB). You can reach the NICB at 1 (800) 835-6422 (callers do not have to disclose their names when reporting fraud to the NICB).
- The Office of the Insurance Commissioner (OIC) at (360) 725-7263 or go to www.insurance.wa.gov for more information.

Extension of Coverage

The "Continuation of Coverage" (COBRA) legislation passed into federal law (PL99-272 and as amended by PL104-191) allows employees and their dependents to continue dental coverage, on a self-pay basis, in certain circumstances where coverage would otherwise cease.

You and/or your covered dependents may continue coverage for up to 18 consecutive months if you lose coverage due to:

- Termination of your employment for any reason other than gross misconduct; or
- A reduction in the number of hours you work.

If one of these events occurs, you will be notified of your opportunity to continue coverage. No proof of insurability is required to obtain coverage.

If you or your dependent are determined to be disabled under Title II or Title XVI of the Social Security Act on the date of the reduction of hours or termination described above or if disability occurs at any time during the first 60 days of COBRA coverage, the disabled individual may be eligible for an additional 11 months of coverage (for a total of 29 months of continued coverage).

You're Department Human Resources or Payroll Representative must be notified within 60 days after the date of determination and within the 18 month coverage period. If you or your dependent is subsequently determined to have recovered, you're Department Human Resources or Payroll Representative must be notified within 30 days of the date of any final determination that the individual is no longer disabled.

Your covered spouse or domestic partner or children may continue his/her own coverage for up to 36 months if loss of coverage is due to:

- Your death;
- Your divorce, legal separation, or termination of domestic partnership;
- Your Medicare entitlement;
- A child losing eligibility for dependent coverage.

Should a dependent lose coverage due to divorce or legal separation, or termination of domestic partnership or cease to meet the dependent eligibility requirements, such individual must notify the Department Human Resources or Payroll Representative within 60 days of the event in order to continue coverage. In other circumstances the City will notify you of your eligibility. No proof of insurability is required to obtain coverage.

If the Covered Employee has a child or adopts a child during the period of COBRA coverage, such employee may elect to cover that child.

If a dependent is self-paying during the 18-month period described above and experiences a second qualifying event such dependent may be eligible to extend coverage for a total of 36 months from the date of the first event. For example, if a dependent is self-paying due to the employee's termination and after seven months the employee and dependent divorce, such dependent may be eligible for an additional 29 months (36 months from the date of the first event) of continued coverage.

When Medicare entitlement is the first qualifying event and termination of employment or reduction of hours occurs later, dependents will be eligible for coverage until the later of: 36 months from the date of Medicare entitlement; or 18 months from the date of termination of employment or reduction of hours. If Medicare entitlement is the second qualifying event, dependents will be eligible for no more than a total of 36 months of continued coverage from the date of the first qualifying event.

Continued coverage for you and/or your dependent will terminate prior to the end of the 18, 29 or 36 month period on the date the first of the following occurs:

- The date the City ceases to maintain any group health plan for employees;
- The date the individual continuing coverage fails to pay any required contribution;

- The first day after the date of the election that the individual continuing coverage is covered under another group health plan. However, if the new coverage does not cover a specific pre-existing condition of the individual, the affected individual may continue COBRA coverage until the earlier of: recovery of the pre-existing condition; or the end of the COBRA eligibility period for any reason.
- The date the individual continuing coverage becomes entitled to benefits under Medicare.

COBRA payments are due within 45 days from the date of application. Payments must be made retroactively from the date of COBRA eligibility up through the current month of eligibility.

Contact your Department Human Resources or Payroll Representative for more information.

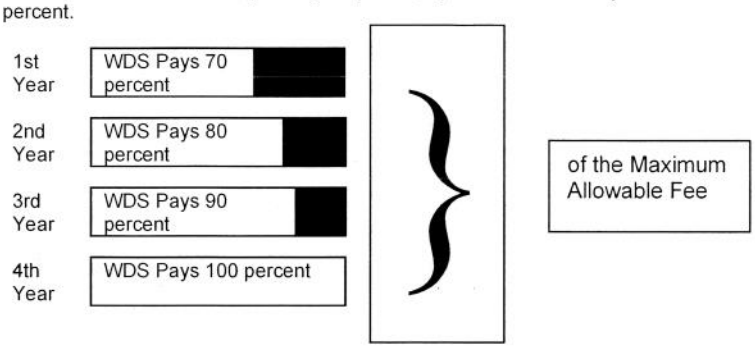
How the Program Works

This program is designed to encourage regular dental care. Each calendar year (January 1 through December 31) WDS pays an increasing share of dental costs. The calendar year is also referred to as your benefit period.

Please be sure to consult your provider regarding any charges that may be your responsibility before treatment begins.

Payment of Basic Services

During the first calendar year, the Payment Level for covered and allowable Basic Services is 70 percent. Basic Services are Class I and Class II Covered Dental Benefits. The Payment Level advances 10 percentage points each successive calendar year during which benefits are utilized by an eligible person, up to a maximum Payment Level of 100 percent.



If an eligible person fails to utilize benefits in a calendar year, the Payment Level will be decreased by 10 percentage points for each intervening calendar year during which benefits are not utilized. This deduction will be made from the last Payment Level used by WDS in making payment for the eligible person. In no event will the Payment Level be less than the starting 70 percent level.

Each eligible person covered by this program establishes his or her own Payment Level through utilization during the calendar years as described above.

In order for the Payment Level to increase, all dental work must be performed while covered by WDS.

Payment for Class II Restorative (Crowns, Veneers, Inlays (Asa Single Tooth Restoration) or Onlays) Services

The Payment Level for covered and allowable Restorative Services (Class II Covered Dental Benefits – Crowns, veneers, inlays (as a single tooth restoration) or onlays), is a constant 70 percent. The incentive provision explained above does not apply to these services.

Payment for Class III Periodontic and Prosthodontic Services

The Payment Level for covered and allowable Periodontic and Prosthodontic Services (Class III Covered Dental Benefits) is a constant 50 percent. The incentive provision explained above does not apply to these services.

Payment for Orthodontic Services

The Payment Level for covered and allowable Orthodontic Services is a constant 50 percent. The incentive provision explained above does not apply to orthodontic benefits.

Benefits Covered By Your Program

The following are Class I, Class II and Class III Covered Dental Benefits under this program which are subject to the limitations and exclusions described in this booklet.

Class I

Diagnostic

Covered Dental Benefits

- Routine examination (periodic oral evaluation)
- Comprehensive oral evaluation
- X-rays
- Emergency examination
- Specialist examination performed by a specialist in an American Dental Association-recognized specialty
- WDS-approved caries (tooth decay) and periodontal susceptibility/risk tests

Limitations

- Routine examination is covered twice in a benefit period.
- Comprehensive oral evaluation is covered once in a three-year period from the date of service per eligible person per dentist. Additional comprehensive oral evaluations are allowed as routine examinations.
  - Comprehensive oral evaluations are considered as one of the two covered examinations per benefit period.
- Complete series (any number or combination of intraoral X-rays, billed for same date of service, that equals or exceeds the allowed fee for a complete series is considered a complete series for payment purposes) or panorex X-rays are covered once in a three-year period from the date of service.
- Supplementary bitewing X-rays are covered twice in a benefit period.
- Diagnostic services and X-rays related to temporomandibular joints (jaw joints) are not a paid covered benefit under Class I benefits.

Exclusions

- Consultations or elective second opinions
- Study models

Preventive

Covered Dental Benefits

- Prophylaxis (cleaning)
- Periodontal maintenance
- Fissure sealants
- Topical application of fluoride or preventive therapies, e.g. fluoridated varnishes
- Space maintainers (with limitations)

Limitations

- Prophylaxis and/or periodontal maintenance are limited to two covered procedures in a benefit period.
- Under certain conditions of oral health, prophylaxis or periodontal maintenance (*but not both*) *may be* covered up to a total of four times in a benefit period.

Note: *These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment is a covered dental benefit. A predetermination is not a guarantee of payment.*

- Topical application of fluoride or preventive therapies (*but not both*) is limited to two covered procedures in a benefit period.
- Fissure sealants:
  - Available for children through age 14.
  - If eruption of permanent molars is delayed, sealants will be allowed if applied within 12 months of eruption with documentation from the attending Dentist.
  - Payment for application of sealants will be for permanent maxillary (upper) or mandibular (lower) molars with incipient or no caries (decay) on an intact occlusal surface.
  - The application of fissure sealants is a covered dental benefit only once in a three-year period per tooth from the date of service.
- Space maintainers:
  - When used to maintain space for eruption of permanent teeth.
  - Replacement of a space maintainer previously paid for by WDS is not a paid covered benefit.

Exclusions

- Plaque control program (oral hygiene instruction, dietary instruction and home fluoride kits)
- Cleaning of prosthetic appliances

****Refer also to General Limitations and General Exclusions****

Class II

Note: *Please be sure to consult your provider regarding any charges that may be your responsibility before treatment begins.*

General Anesthesia

Covered Dental Benefits

- General anesthesia when administered by a licensed dentist or other WDS-approved licensed professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the state of Washington or as determined by the state in which the services are provided.

Limitations

- —General anesthesia is covered in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by WDS, or when medically necessary, for children through age six, or a physically or developmentally disabled person, when in conjunction with Class I, II, III and Orthodontic covered dental procedures.
- —Either general anesthesia or intravenous sedation (but not both) are covered when performed on the same day.
- —General anesthesia for routine post-operative procedures is not a paid covered benefit.

Intravenous Sedation

Covered Dental Benefits

- —Intravenous sedation when administered by a licensed dentist or other WDS-approved licensed professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the state of Washington or as determined by the state in which the services are provided.

Limitations

- —Intravenous sedation is covered in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by WDS.
- —Either general anesthesia or intravenous sedation (*but not both*) are covered when performed on the same day.
- —Intravenous sedation for routine post-operative procedures is not a paid covered benefit.

Palliative Treatment

Covered Dental Benefits

- —Palliative treatment for pain

Limitations

- —Postoperative care and treatment of routine post-surgical complications are included in the initial cost for surgical treatment if performed within 30 days.

Restorative

Covered Dental Benefits

- —Amalgam restorations (fillings) and, in anterior (front) teeth, resin-based composite or glass ionomer restorations are covered for the following reasons:
  - o Treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay)
  - o Fracture resulting in significant loss of tooth structure (missing cusp)
  - o Fracture resulting in significant damage to an existing restoration
- —Resin-based composite or glass ionomer restorations placed in the buccal (facial) surface of bicuspids.
- —Stainless steel crowns

— Crowns, veneers, inlays (as a single tooth restoration – with limitations) or onlays (whether they are gold, porcelain, WDS-approved gold substitute castings [except laboratory processed resin]" or combinations thereof) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay) or fracture resulting in significant loss of tooth structure (missing cusp), when teeth cannot reasonably be restored with filling materials such as amalgam or resin-based composites.
— Crown buildups, subject to limitations
— Post and core, subject to limitations

Limitations

— Restorations on the same surface(s) of the same tooth are covered once in a two-year period from the date of service.
— If a resin-based composite or glass ionomer restoration is placed in a posterior tooth (except on bicuspids as noted above), it will be considered as a cosmetic procedure and an amalgam allowance will be made, with any difference in cost being the responsibility of the patient.
— Restorations necessary to correct vertical dimension or to alter the morphology (shape) or occlusion are not a paid covered benefit.
— Stainless steel crowns are covered once in a two-year period from the seat date.
— Crowns, veneers, inlays (as a single tooth restoration – with limitations) or onlays on the same teeth are covered once in a five-year period from the original seat date.
— Payment for crowns, veneers, inlays (as a single tooth restoration – with limitations) or onlays shall be paid upon the seat date.
— Inlays (as a single tooth restoration) will be considered as a cosmetic procedure and an amalgam allowance will be made, with any difference in cost being the responsibility of the patient.
— If a tooth can be restored with a filling material such as amalgam or resin-based composites, an allowance will be made for such a procedure toward the cost of any other type of restoration that may be provided.
— WDS will allow the appropriate amount for an amalgam restoration (posterior tooth) or resin-based composite restoration (anterior tooth) toward the cost of a laboratory processed resin onlay, veneer, crown or inlay (as a single tooth restoration – with limitations).
— Crown buildups are a covered dental benefit when more than 50 percent of the natural coronal tooth structure is missing or there is less than 2mm of vertical height remaining for 180 degrees or more of the tooth circumference and there is evidence of decay or other significant pathology.
  - Crown buildups are covered once in a two-year period from the date of service.
  - Crown buildups are not a paid covered benefit within two years of a restoration on the same tooth from the date of service.
  - Crown buildups for the purpose of improving tooth form, filling in undercuts, or reducing bulk in castings are considered basing materials and are not a paid covered benefit.
— Post and core are covered once in a five-year period on the same tooth from the date of service.

— A crown used for purposes of re-contouring or repositioning a tooth to provide additional retention for a removable partial denture is not a paid covered benefit unless the tooth is decayed to the extent that a crown would be required to restore the tooth, whether or not a removable partial denture is part of the treatment.
— Crowns or onlays are not a paid covered benefit when used to repair micro-fractures of tooth structure when the tooth is asymptomatic (displays no symptoms) or there are existing restorations with defective margins when there is no decay or other significant pathology present.
— Crowns and/or onlays placed because of weakened cusps or existing large restorations without overt pathology are not a paid covered benefit.
— Crown and bridgework in conjunction with periodontal splinting or other periodontal therapy and periodontal appliances are not a paid covered benefit.

Exclusions

— Overhang removal
— Copings
— Re-contouring or polishing of restoration

Oral Surgery

Covered Dental Benefits

— Removal of teeth
— Preparation of the mouth for insertion of dentures
— Treatment of pathological conditions and traumatic injuries of the mouth
— *Refer to Class II General Anesthesia or Intravenous Sedation for information.*

Exclusions

— Bone replacement graft for ridge preservation
— Bone grafts, of any kind, to the upper or lower jaws not associated with periodontal treatment of teeth
— Tooth transplants
— Materials placed in tooth extraction sockets for the purpose of generating osseous filling

Periodontics

Covered Dental Benefits

- Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth
- Services covered include:
  - Periodontal scaling/root planing
  - Periodontal surgery
  - Limited adjustments to occlusion (eight teeth or fewer)
  - WDS-approved localized delivery of antimicrobial agents
- *Refer to Class I Preventive for periodontal maintenance benefits.*
- *Refer to Class III Periodontics for occlusal equilibration and occlusal guard.*

Note: *Some benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment is a covered dental benefit. A predetermination is not a guarantee of payment.*

Limitations

- Periodontal scaling/root planing is covered once in a three-year period from the date of service.
- Periodontal surgery (per site) is covered once in a three-year period from the date of service.
  - Periodontal surgery must be preceded by scaling and root planing a minimum of six weeks and a maximum of six months, or the patient must have been in active supportive periodontal therapy, prior to such treatment.
- Soft tissue grafts (per site) are covered once in a three-year period from the date of service.
- Limited occlusal adjustments are covered once in a 12-month period from the date of service.
- Crown and bridgework in conjunction with periodontal splinting or other periodontal therapy and periodontal appliances are not a paid covered benefit.
- Localized delivery of antimicrobial agents approved by WDS is a covered dental benefit under certain conditions of oral health.
  - Localized delivery of antimicrobial agents is limited to two teeth per quadrant and up to two times (per tooth) in a benefit period.
  - Localized delivery of antimicrobial agents must be preceded by scaling and root planing a minimum of six weeks and a maximum of six months, or the patient must have been in active supportive periodontal therapy, prior to such treatment.
  - Localized delivery of antimicrobial agents is not a paid covered benefit when used for the purpose of maintaining non-covered dental procedures.

Exclusions

- Gingival curettage
- Occlusal guard (nightguard)
- Major (complete) occlusal adjustment

Endodontics

Covered Dental Benefits

- Procedures for pulpal and root canal treatment, services covered include:
  - Pulp exposure treatment
  - Pulpotomy
  - Apicoectomy

Limitations

- Root canal treatment on the same tooth is covered only once in a two-year period from the date of service.
- Re-treatment of the same tooth is allowed when performed by a different dental office.
- *Refer to Class III Prosthodontics for root canals placed in conjunction with a prosthetic appliance.*

Exclusions

- Bleaching of teeth

****Refer also to General Limitations and General Exclusions****

Class III

Note: *Please be sure to consult your provider regarding any charges that may be your responsibility before treatment begins.*

Periodontics

Covered Dental Benefits

- Under certain conditions of oral health, services covered are:
  - Occlusal guard (nightguard)
  - Repair and relines of occlusal guard
  - Complete occlusal equilibration

Note: *These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment is a covered dental benefit. A predetermination is not a guarantee of payment.*

Limitations

- Occlusal guard (nightguard) is covered once in a three-year period from the date of service.
- Repair and relines done more than six months after the date of initial placement are covered.
- Complete occlusal equilibration is covered once in a lifetime.

Prosthodontics

Covered Dental Benefits

- Dentures
- Fixed partial dentures (fixed bridges)
- Inlays (only when used as a retainer for a fixed bridge)
- Removable partial dentures
- Adjustment or repair of an existing prosthetic device
- Surgical placement or removal of implants or attachments to implants

Limitations

- Replacement of an existing prosthetic device is covered only once every five years from the delivery date and only then if it is unserviceable and cannot be made serviceable.
- Inlays are a covered dental benefit on the same teeth once in a five-year period from the delivery date only when used as a retainer for a fixed bridge.
- Payment for dentures, fixed partial dentures (fixed bridges); inlays (only when used as a retainer for a fixed bridge) and removable partial dentures shall be paid upon the delivery date.
- Replacement of implants and superstructures is covered only after five years have elapsed from any prior provision of the implant.
- Implant maintenance procedures, including:
  - Removal of prosthesis
  - Cleansing of prosthesis and abutments
  - Reinsertion of prosthesis
- Crowns in conjunction with overdentures are not a paid covered benefit.

- **Full, immediate and overdentures** — WDS will allow the appropriate amount for a full, immediate or overdenture toward the cost of any other procedure that may be provided, such as personalized restorations or specialized treatment.
- Root canal treatment performed in conjunction with overdentures is limited to two teeth per arch and is paid at the Class III payment level.
- **Temporary/interim dentures** — WDS will allow the amount of a reline toward the cost of an interim partial or full denture. After placement of the permanent prosthesis, an initial reline will be a benefit after six months.
- **Partial dentures** — If a more elaborate or precision device is used to restore the case, WDS will allow the cost of a cast chrome and acrylic partial denture toward the cost of any other procedure that may be provided.
- **Denture adjustments and relines** — Denture adjustments and relines done more than six months after the initial placement are covered. Subsequent relines or rebases (*but not both*) will be covered once in a 12-month period from the date of service.

Exclusions

- Duplicate dentures
- Personalized dentures
- Maintenance or cleaning of prosthetic appliances
  - Except for implant maintenance
- Copings

****Refer also to General Limitations and General Exclusions****

Orthodontic Benefits for Eligible Children

Orthodontic treatment is defined as the necessary procedures of treatment, performed by a licensed dentist, involving surgical or appliance therapy for movement of teeth and post-treatment retention.

The lifetime maximum amount payable by WDS for orthodontic benefits provided to an eligible person shall be $1,500. Not more than $750 of the maximum, or one-half of WDS's total responsibility shall be payable at the time of initial banding. The final payment of WDS's responsibility shall be made during the seventh month following the initial banding, providing the employee is eligible and the dependent is in compliance with the age limitation.

It is strongly suggested that an orthodontic treatment plan be submitted to, and a predetermination be made by, WDS prior to commencement of treatment. A predetermination is not a guarantee of payment. Additionally, payment for orthodontic benefits is based upon eligibility. If individuals become ineligible prior to the payment of benefits, subsequent payment is not covered.

Covered Dental Benefits

- Treatment of malalignment of teeth and/or jaws. Orthodontic records: exams (initial, periodic, comprehensive, detailed and extensive), X-rays (intraoral, extraoral, diagnostic radiographs, panoramic), diagnostic photographs, diagnostic casts (study models) or cephalometric films.

Limitations

- —Payment is limited to:
  - o Completion, or through limiting age (refer to Dependent Eligibility and Termination), whichever occur first.
  - o Treatment received after coverage begins (claims must be submitted to WDS within the time limitation stated in the Claim Forms Section of the start of coverage). For orthodontia claims, the initial banding date is the treatment date considered in the timely filing.
- —Treatment that began prior to the start of coverage will be prorated:
  - o Payment is made based on the balance remaining after the down payment and charges prior to the date of eligibility are deducted.
  - o WDS will issue payments based on our responsibility for the length of the treatment. The payments are issued providing the employee is eligible and the dependent is in compliance with the age limitation.
- —In the event of termination of the treatment plan prior to completion of the case or termination of this plan, no subsequent payments will be made for treatment incurred after such termination date.

Exclusions

- —Charges for replacement or repair of an appliance
- —No benefits shall be provided for services considered inappropriate and unnecessary, as determined by WDS.

****Refer also to General Limitations and General Exclusions****

Additional Procedures

In some cases, there may be two or more treatment options that meet the standard of care for dental needs covered by the plan. In such instances, the plan will pay the proper percentage of the lowest fee. The balance of treatment cost remains the eligible person's responsibility.

General Limitations

1. Dentistry for cosmetic reasons is not a paid covered benefit.
2. Restorations or appliances necessary to correct vertical dimension or to restore the occlusion. Such procedures, which include restoration of tooth structure lost from attrition, abrasion or erosion and restorations for malalignment of teeth, are not a paid covered benefit.
3. General anesthesia/intravenous (deep) sedation is not a paid covered benefit, except as specified by WDS for certain oral, periodontal, or endodontic surgical procedures. General anesthesia is not a paid covered benefit except when medically necessary, for children through age six, or a physically or developmentally disabled person, when in conjunction with covered dental procedures.

General Exclusions

1. Services for injuries or conditions that are compensable under Worker's Compensation or Employers' Liability laws, and services that are provided to the eligible person by any federal or state or provincial government agency or provided without cost to the eligible person by any municipality, county, or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 1396a, section 1902 of the Social Security Act.
2. Application of desensitizing agents
3. Experimental services or supplies, which include:
   a. Procedures, services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are experimental, WDS, in conjunction with the American Dental Association, will consider them if:
      i) The services are in general use in the dental community in the state of Washington;
      ii) The services are under continued scientific testing and research;
      iii) The services show a demonstrable benefit for a particular dental condition; and
      iv) They are proven to be safe and effective.

      Any individual whose claim is denied due to this experimental exclusion clause will be notified of the denial within 20 working days of receipt of a fully documented request.
   b. Any denial of benefits by WDS on the grounds that a given procedure is deemed experimental may be appealed to WDS. By law, WDS must respond to such appeal within 20 working days after receipt of all documentation reasonably required to make a decision. The 20-day period may be extended only with written consent of the eligible person.
   c. Whenever WDS makes an adverse determination and delay would jeopardize the eligible person's life or materially jeopardize the covered person's health, WDS shall expedite and process either a written or an oral appeal and issue a decision no later than seventy-two hours after receipt of the appeal. If the treating Licensed Professional determines that delay could jeopardize the eligible person's health or ability to regain maximum function, WDS shall presume the need for expeditious review, including the need for an expeditious determination in any independent review under WAC 284-43-630.
4. Analgesics such as nitrous oxide, conscious sedation, euphoric drugs or injections
5. Prescription drugs
6. In the event an eligible person fails to obtain a required examination from a WDS-appointed consultant dentist for certain treatments, no benefits shall be provided for such treatment.
7. Hospitalization charges and any additional fees charged by the dentist for hospital treatment
8. Broken appointments
9. Patient management problems
10. Completing claim forms

11. Habit-breaking appliances
12. TMJ services or supplies
13. This plan does not provide benefits for services or supplies to the extent that benefits are payable for them under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection (PIP), commercial liability, homeowner's policy, or other similar type of coverage.
14. All other services not specifically included in this plan as covered dental benefits.

WDS shall determine whether services are Covered Dental Benefits in accordance with standard dental practice and the Limitations and Exclusions shown in this benefits booklet. Should there be a disagreement regarding the interpretation of such benefits, the subscriber shall have the right to appeal the determination in accordance with the non-binding appeals process in this benefits booklet and may seek judicial review of any denial of coverage of benefits.

Claim Review and Appeal

Predetermination of Benefits

A predetermination is a request made by your dentist to Washington Dental Service to determine your benefits for a particular service. This predetermination will provide you and your dentist with general coverage information regarding your benefits and your potential out-of-pocket cost for services. Please be aware that the predetermination is not a guarantee of payment but strictly an estimate for services. Payment for services is determined when the claim is submitted (please refer to the Initial Benefits Determination section regarding claims requirements).

A standard predetermination is processed within 15 days from the date of receipt if all appropriate information is completed. If it is incomplete, Washington Dental Service may request additional information, request an extension of 15 days and pend the predetermination until all of the information is received. Once all of the information is received a determination will be made within 15 days of receipt. If no information is received at the end of 45 days, the predetermination will be denied.

Urgent Predetermination Requests

Should a predetermination request be of an urgent nature, whereby a delay in the standard process may seriously jeopardize life, health, the ability to regain maximum function, or could cause severe pain in the opinion of a physician or dentist who has knowledge of the medical condition, Washington Dental Service will review the request within 72-hours from receipt of the request and all supporting documentation. When practical, WDS may provide notice of determination orally with written or electronic confirmation to follow within 72 hours.

Immediate treatment is allowed without a requirement to obtain a predetermination in an emergency situation subject to the contract provisions.

Initial Benefit Determinations

An initial benefit determination is conducted at the time of claim submission to Washington Dental Service for payment, modification, or denial of services. In accordance with regulatory requirements, WDS processes all clean claims within 30 days from the date of receipt. Clean claims are claims that have no defect or impropriety, including a lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim. Claims not meeting this definition are paid or denied within 60 days of receipt.

If a claim is denied, in whole or in part, or is modified, you will be furnished with a written explanation of benefits (EOB) that will include the following information:

- The specific reason for the denial or modification
- Reference to the specific plan provision on which the determination was based
- Your appeal rights should you wish to dispute the original determination

Appeals of Denied Claims

Informal Review

If your claim for dental benefits has been completely or partially denied, you have the right to request an informal review of the decision. Either you, or your authorized representative (see below), must submit your request for a review within 180 days from the date your claim was denied (please see your explanation of benefits form). A request for a review may be made orally or in writing, and must include the following information:

- Your name and ID number
- The group name and number
- The claim number (from your explanation of benefits form)
- The name of the dentist

Please submit your request for a review to:

Washington Dental Service
Attn: Appeals Coordinator
P.O. Box 75983
Seattle, WA 98175-0983

For oral appeals, please refer to the phone numbers listed on the inside front cover of your benefit booklet.

You may include any written comments, documents or other information that you believe supports your claim.

Washington Dental Service will review your claim and make a determination within 30 days of receiving your request and send you a written notification of the review decision. Upon request, you will be granted access to and copies of all relevant information used in making the review decision.

Informal reviews of wholly or partially denied claims are conducted by persons not involved in the initial claim determination. In the event the review decision is based in whole or in part on a dental clinical judgment as to whether a particular treatment, drug or other service is experimental or investigational in nature, Washington Dental Service will consult with a dental professional advisor.

Appeals Committee

If you are dissatisfied with the outcome of the informal review, you may request that your claim be reviewed formally by the Washington Dental Service Appeals Committee. This Committee includes only persons who were not involved in either the original claim decision or the informal review.

Your request for a review by the Appeals Committee must be made within 90 days of the post-marked date of the letter notifying you of the informal review decision. Your request should include the information noted above plus a copy of the informal review decision letter. You may also submit any other documentation or information you believe supports your case.

The Appeals Committee will review your claim and make a determination within 30 days of receiving your request or within 20 days for experimental/investigational procedures appeals and sends you a written notification of the review decision. Upon request, you will be granted access to and copies of all relevant information used in making the review decision. In the event the review decision is based in whole or in part on a dental clinical judgment as to whether a particular treatment, drug or other service is experimental or investigational in nature, WDS will consult with a dental professional advisor.

The decision of the Appeals Committee is final. If you disagree with this the outcome of your appeal and you have exhausted the appeals process provided by your group plan, there may be other avenues available for further action. If so, these will be provided to you in the final decision letter.

Authorized Representative

You may authorize another person to represent you and to whom Washington Dental Service can communicate regarding specific appeals. The authorization must be in writing and signed by you. If an appeal is submitted by another party without this authorization, a request will be made to obtain a completed Authorized Representative form. The appeal process will not commence until this form is received. Should the form not be returned or any document confirming the right of the individual to act on your behalf (i.e., power of attorney), the appeal will be closed.

Subrogation

Based on the following legal criteria, subrogation means that if you receive this program's benefits for an injury or condition possibly caused by another person, you must include in your insurance claim or liability claim the amount of those benefits. After you have been fully compensated for your loss any money recovered in excess of full compensation must be used to reimburse Washington Dental Service. Washington Dental Service will prorate any attorneys' fees against the amount owed.

To the extent of any amounts paid by Washington Dental Service for an eligible person on account of services made necessary by an injury to or condition of his or her person, Washington Dental Service shall be subrogated to his or her rights against any third party liable for the injury or condition. Washington Dental Service shall, however, not be obligated to pay for such services unless and until the eligible person, or someone legally qualified and authorized to act for him or her, agrees to:

— Include those amounts in any insurance claim or in any liability claim made against the third party for the injury or condition;
— Repay Washington Dental Service those amounts included in the claim from the excess received by the injured party, after full compensation for the loss is received;
— Cooperate fully with Washington Dental Service in asserting its rights under the contract, to supply WDS with any and all information and execute any and all instruments Washington Dental Service reasonably needs for that purpose.

Provided the injured party is in compliance with the above, Washington Dental Service will prorate any attorneys' fees incurred in the recovery.

Subscriber Rights and Responsibilities

At Washington Dental Service our mission is to provide quality dental benefit products to employers and employees throughout Washington through the largest network of participating dentists in the state of Washington. We view our benefit packages as a partnership between Washington Dental Service, our subscribers and our participating members' dentists. All partners in this process play an important role in achieving quality oral health services. We would like to take a moment and share our views of the rights and responsibilities that make this partnership work.

You Have The Right To:

- Seek care from any licensed dentist in Washington or nationally. Our reimbursement for such care varies depending on your choice (Delta member/non-member), but you can receive care from any dentist you choose.
- Participate in decisions about your oral health care.
- Be informed about the oral health options available to you and your family.
- Request information concerning benefit coverage levels for proposed treatments prior to receiving services.
- Have access to specialists when services are required to complete a treatment, diagnosis or when your primary care dentist makes a specific referral for specialty care.
- Contact Washington Dental Service customer service personnel during established business hours to ask questions about your oral health benefits. Alternatively, information is available on our website at deltadentalwa.com

- Appeal orally or in writing, decisions or grievances regarding your dental benefit coverage. You should expect to have these issues resolved in a timely, professional and fair manner.
- Have your individual health information kept confidential and used only for resolving health care decisions or claims.
- Receive quality care regardless of your gender, race, sexual orientation, marital status, cultural, economic, educational or religious background.

To Receive The Best Oral Health Care Possible, It Is Your Responsibility To:

- Know your benefit coverage and how it works.
- Arrive at the dental office on time or let the dental office know well in advance if you are unable to keep a scheduled appointment. Some offices require 24 hours notice for appointment cancellations before they will waive service charges.
- Ask questions about treatment options that are available to you regardless of coverage levels or cost.
- Give accurate and complete information about your health status and history and the health status and history of your family to all care providers when necessary.
- Read carefully and ask questions about all forms and documents that you are requested to sign, and request further information about items you do not understand.
- Follow instructions given by your dentist or their staff concerning daily oral health improvement or post-service care.
- Send requested documentation to Washington Dental Service to assist with the processing of claims.
- If applicable, pay the dental office the appropriate co-payments amount at time of visit.
- Respect the rights, office policies and property of each dental office you have the opportunity to visit.

Inform your dentist and your employer promptly of any change to your or a family member's address, telephone, or family status.

Washington Dental Service, a member of the nationwide Delta Dental Plans Association, has been working to improve the oral health of our subscribers and our community since 1954. Today we cover more than 50 million people nationwide through our Delta Dental plans.

We specialize exclusively in dental benefits, which allows us to offer the most knowledgeable customer service and to partner with our large participating dentist networks to offer you the widest choice of dentists. We are an innovative company that is a national leader in supporting dental research so that we can include the latest effective dental treatments in our plans. Healthy teeth for a wonderful smile – that is what we are all about!

To learn more about Washington Dental Service and your benefits, visit our Internet Web site at **www.DeltaDentalWA.com**.

Plan Administered by:

Personnel Department

City of Seattle

City of Seattle Policy #5
Local 77

Group #00160

Effective January 1, 2011, the following benefit information has been revised or added in your Benefit Booklet. We have identified the section that is changing with all **changes in bold print**.

Dependent Eligibility

Eligible Dependents include:

- The employee's legal spouse/state registered domestic partner or non-registered domestic partner named on the Affidavit of Marriage/Domestic Partnership on file with the City.
- Natural, adopted, legally placed ward or stepchild from birth through **25**. Spouses and children of married dependents are not eligible for coverage under this plan.
- In the case of divorced parents, children are eligible and may be enrolled by the parent (an eligible employee) who is legally responsible for health care benefits, regardless of whether or not the child is primarily dependent upon the employee for support. The child shall be eligible from birth through **25**.

Coverage for **a dependent child** over the limiting age will not be terminated if the child is and continues to be both 1) incapable of self sustaining employment by reasons of developmental disability (including mental retardation, cerebral palsy, epilepsy, autism, or another neurological condition closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals) or physical handicap and 2) chiefly dependent upon the eligible person for support and maintenance, provided proof of incapacity and dependency is furnished to WDS within 31 days of the child's attainment of the limiting age and the child was an eligible dependent upon attainment of the limiting age. WDS reserves the right to periodically verify the disability and dependency but not more frequently than annually after the first two years.

Coordination of Benefits

Coordination of This Contract's Benefits with Other Benefits: The coordination of benefits (COB) provision applies when you have dental coverage under more than one *Plan*. *Plan* is defined below.

The order of benefit determination rules govern the order in which each *Plan* will pay a claim for benefits. The *Plan* that pays first is called the *Primary Plan*. The *Primary Plan* must pay benefits according to its policy terms without regard to the possibility that another *Plan* may cover some expenses. The *Plan* that pays after the *Primary Plan* is the *Secondary Plan*. The *Secondary Plan* may reduce the benefits it pays so that payments from all *Plans* do not exceed 100 percent of the total *Allowable Expense*.

Definitions: For the purpose of this section, the following definitions shall apply:

A "*Plan*" is any of the following that provides benefits or services for dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same *Plan* and there is no COB among those separate contracts. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate *Plan*.

- ***Plan* includes: group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), *Closed Panel Plans* or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental *Plan*, as permitted by law.**
- ***Plan* does not include: hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident and similar coverage that cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a "to and from school" basis; benefits for nonmedical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; A state *plan* under Medicaid; A governmental *plan*, which, by law, provides benefits that are in excess of those of any private insurance *plan* or other nongovernmental *plan*; automobile insurance policies required by statute to provide medical benefits; benefits provided as part of a direct agreement with a direct patient-provider primary care practice as defined by law or coverage under other federal governmental *Plans*, unless permitted by law.**

Each contract for coverage under the above bullet points is a separate *Plan*. If a *Plan* has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate *Plan*.

"*This Plan*" means, in a COB provision, the part of the contract providing the dental benefits to which the COB provision applies and which may be reduced because of the benefits of other *Plans*. Any other part of the contract providing dental benefits is separate from *This Plan*. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether *This Plan* is a *Primary Plan* or *Secondary Plan* when you have dental coverage under more than one *Plan*.

When *This Plan* is primary, it determines payment for its benefits first before those of any other *Plan* without considering any other *Plan*'s benefits. When *This Plan* is secondary, it determines its benefits after those of another *Plan* and must make payment in an amount so that, when combined with the amount paid by the *Primary Plan*, the total benefits paid or provided by all *Plan*s for the claim are coordinated up to 100 percent of the total *Allowable Expense* for that claim. This means that when *This Plan* is secondary, it must pay the amount which, when combined with what the *Primary Plan* paid, does not exceed 100 percent of the highest *Allowable Expense*. In addition, if *This Plan* is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the *Primary Plan*) and record these savings as a benefit reserve for you. This reserve must be used to pay any expenses during that calendar year, whether or not they are an *Allowable Expense* under *This Plan*. If *This Plan* is secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

"*Allowable Expense*" is a dental care expense, including coinsurance or copayments and without reduction for any applicable deductible, that is covered in full or in part by any of the *Plans* covering you. When coordinating benefits, any *Secondary Plans* must pay an amount which, together with the payment made by the *Primary Plan*, does not exceed the higher of the allowable expenses. In no event will a *Secondary Plan* be required to pay an amount in excess of its maximum benefit plus accrued savings. When Medicare, Part A and Part B or Part C are primary, Medicare's allowable amount is the highest allowable expense. When a *plan* provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

An expense or a portion of an expense that is not covered by any of the *plan*s is not an allowable expense. The following are examples of expenses that are not *Allowable Expense*s:

- If you are covered by two or more *Plan*s that compute their benefit payments on the basis of a relative value schedule reimbursement method or other similar reimbursement method, any amount charged by the provider in excess of the highest reimbursement amount for a specific benefit is not an *Allowable Expense*.
- If you are covered by two or more *Plan*s that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an *Allowable Expense*.

"*Closed Panel Plan*" is a *Plan* that provides dental benefits to you in the form of services through a panel of providers who are primarily employed by the *Plan*, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

"*Custodial Parent*" is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the calendar year without regard to any temporary visitation.

Order of Benefit Determination Rules: When you are covered by two or more *Plan*s, the rules for determining the order of benefit payments are as follows:

The *Primary Plan* must pay or provide its benefits as if the *Secondary Plan* or *Plan*s did not exist.

A *Plan* that does not contain a coordination of benefits provision that is consistent with Chapter 284-51 of the Washington Administrative Code is always primary unless the provisions of both *Plan*s state that the complying *Plan* is primary, except coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage is excess to any other parts of the *Plan* provided by the contract holder.

A *Plan* may consider the benefits paid or provided by another *Plan* in calculating payment of its benefits only when it is secondary to that other *Plan*.

Each *Plan* determines its order of benefits using the first of the following rules that apply:

"*Non-Dependent or Dependent*:" The *Plan* that covers you other than as a *Dependent*, for example as an employee, member, policyholder, subscriber or retiree is the *Primary Plan* and the *Plan* that covers you as a *Dependent* is the *Secondary Plan*. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the *Plan* covering you as a *Dependent*, and primary to the *Plan* covering you as other than a *Dependent* (e.g., a retired employee), then the order of benefits between the two *Plan*s is reversed so that the *Plan* covering you as an employee, member, policyholder, subscriber or retiree is the *Secondary Plan* and the other *Plan* is the *Primary Plan*.

"*Dependent Child Covered Under More Than One Plan:*" Unless there is a court decree stating otherwise, when a *Dependent* child is covered by more than one *Plan* the order of benefits is determined as follows:

1) For a *Dependent* child whose parents are married or are living together, whether or not they have ever been married:

    a) The *Plan* of the parent whose birthday falls earlier in the calendar year is the *Primary Plan*; or

    b) If both parents have the same birthday, the *Plan* that has covered the parent the longest is the *Primary Plan*.

2) For a *Dependent* child whose parents are divorced or separated or not living together, whether or not they have ever been married:

    a) If a court decree states that one of the parents is responsible for the Dependent child's dental expenses or dental coverage and the *Plan* of that parent has actual knowledge of those terms, that *Plan* is primary. This rule applies to claims determination periods commencing after the *Plan* is given notice of the court decree;

    b) If a court decree states one parent is to assume primary financial responsibility for the Dependent child but does not mention responsibility for dental expenses, the *Plan* of the parent assuming financial responsibility is primary;

    c) If a court decree states that both parents are responsible for the Dependent child's dental expenses or dental coverage, the provisions of the first bullet point above (for dependent child(ren) whose parents are married or are living together) determine the order of benefits;

    d) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the dental expenses or dental coverage of the Dependent child, the provisions of the first bullet point above (for dependent child(ren) whose parents are married or are living together) determine the order of benefits; or

e) If there is no court decree allocating responsibility for the Dependent child's dental expenses or dental coverage, the order of benefits for the child is as follows:

I. The *Plan* covering the *Custodial Parent*, first;
II. The *Plan* covering the spouse of the *Custodial Parent*, second;
III. The *Plan* covering the non*custodial Parent*, third; and then
IV. The *Plan* covering the spouse of the non*custodial Parent*, last

3) For a *Dependent* child covered under more than one *Plan* of individuals who are not the parents of the child, the provisions of the first or second bullet points above (for *dependent* child(ren) whose parents are married or are living together or for *dependent* child(ren) whose parents are divorced or separated or not living together) determine the order of benefits as if those individuals were the parents of the child.

"*Active Employee or Retired or Laid-off Employee:*" The *Plan* that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the *Primary Plan*. The *Plan* covering you as a retired or laid-off employee is the *Secondary Plan*. The same would hold true if you are a *Dependent* of an active employee and you are a *Dependent* of a retired or laid-off employee. If the other *Plan* does not have this rule, and as a result, the *Plans* do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the *Non-Dependent* or *Dependent* provision above can determine the order of benefits.

"*COBRA or State Continuation Coverage:*" If your coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another *Plan*, the *Plan* covering you as an employee, member, subscriber or retiree or covering you as a *Dependent* of an employee, member, subscriber or retiree is the *Primary Plan* and the COBRA or state or other federal continuation coverage is the *Secondary Plan*. If the other *Plan* does not have this rule, and as a result, the *Plans* do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the *Non-Dependent* or *Dependent* provision above can determine the order of benefits.

"*Longer or Shorter Length of Coverage:*" The *Plan* that covered you as an employee, member, policyholder, subscriber or retiree longer is the *Primary Plan* and the *Plan* that covered you the shorter period of time is the *Secondary Plan*.

If the preceding rules do not determine the order of benefits, the *Allowable Expenses* must be shared equally between the *Plans* meeting the definition of *Plan*. In addition, *This Plan* will not pay more than it would have paid had it been the *Primary Plan*.

Effect on the Benefits of *This Plan*: When *This Plan* is secondary, it may reduce its benefits so that the total benefits paid or provided by all *Plans* during a claim determination period are not more than the *Total Allowable Expenses*. In determining the amount to be paid for any claim, the *Secondary Plan* must make payment in an amount so that, when combined with the amount paid by the *Primary Plan*, the total benefits paid or provided by all *Plans* for the claim do not exceed 100 percent of the total *Allowable Expense* for that claim. Total *Allowable Expense* is the highest *Allowable Expense* of the *Primary Plan* or the *Secondary Plan*. In addition, the *Secondary Plan* must credit to its *Plan* deductible any amounts it would have credited to its deductible in the absence of other dental coverage.

How We Pay Claims When We Are Secondary: When we are knowingly the *Secondary Plan*, we will make payment promptly after receiving payment information from your *Primary Plan*. Your *Primary Plan*, and we as your *Secondary Plan*, may ask you and/or your provider for information in order to make payment. To expedite payment, be sure that you and/or your provider supply the information in a timely manner.

If the *Primary Plan* fails to pay within 60 calendar days of receiving all necessary information from you and your provider, you and/or your provider may submit your claim for us to make payment as if we were your *Primary Plan*. In such situations, we are required to pay claims within 30 calendar days of receiving your claim and the notice that your *Primary Plan* has not paid. This provision does not apply if Medicare is the *Primary Plan*. We may recover from the *Primary Plan* any excess amount paid under the "right of recovery" provision in the *plan*.

- If there is a difference between the amounts the *plan*s allow, we will base our payment on the higher amount. However, if the *Primary Plan* has a contract with the provider, our combined payments will not be more than the amount called for in our contract or the amount called for in the contract of the *Primary Plan*, whichever is higher. Health maintenance organizations (HMOs) and health care service contractors usually have contracts with their providers as do some other *plan*s.
- We will determine our payment by subtracting the amount paid by the *Primary Plan* from the amount we would have paid if we had been primary. We must make payment in an amount so that, when combined with the amount paid by the *Primary Plan*, the total benefits paid or provided by all *plan*s for the claim does not exceed one hundred percent of the total allowable expense (the highest of the amounts allowed under each *plan* involved) for your claim. We are not required to pay an amount in excess of our maximum benefit plus any accrued savings. If your provider negotiates reimbursement amounts with the *plan*(s) for the service provided, your provider may not bill you for any excess amounts once he/she has received payment for the highest of the negotiated amounts. When our deductible is fully credited, we will place any remaining amounts in a savings account to cover future claims which might not otherwise have been paid.

Right to Receive and Release Needed Information: Certain facts about dental coverage and services are needed to apply these COB rules and to determine benefits payable under *This Plan* and other *Plan*s. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under *This Plan* and other *Plan*s covering you. The Company need not tell, or get the consent of, any person to do this. To claim benefits under *This Plan* you must give the Company any facts it needs to apply those rules and determine benefits payable.

Facility of Payment: If payments that should have been made under *This Plan* are made by another *Plan*, the Company has the right, at its discretion, to remit to the other *Plan* the amount the Company determines appropriate to satisfy the intent of this provision. The amounts paid to the other *Plan* are considered benefits paid under *This Plan*. To the extent of such payments, the Company is fully discharged from liability under *This Plan*.

Right of Recovery: The Company has the right to recover excess payment whenever it has paid *Allowable Expense*s in excess of the maximum amount of payment necessary to satisfy the intent of this provision. The Company may recover excess payment from any person to whom or for whom payment was made or any other Company or *Plan*s.

If payments that should have been made under *This Plan* are made by another *Plan*, WDS has the right, at its discretion, to remit to the other *Plan* the amount it determines appropriate. To the extent of such payments, WDS is fully discharged from liability under *This Plan*.

Notice to covered persons If you are covered by more than one health benefit *Plan*, and you do not know which is your *Primary Plan*, you or your provider should contact any one of the health *Plan*s to verify which *Plan* is primary. The health *Plan* you contact is responsible for working with the other health *Plan* to determine which is primary and will let you know within 30 calendar days.

CAUTION: All health *Plan*s have timely claim filing requirements. If you, or your provider, fail to submit your claim to a secondary health *Plan* within the *Plan*'s claim filing time limit, the *Plan* can deny the claim. If you experience delays in the processing of your claim by the primary health *Plan*, you or your provider will need to submit your claim to the secondary health *Plan* within its claim filing time limit to prevent a denial of the claim.

To avoid delays in claims processing, if you are covered by more than one *Plan* you should promptly report to your providers and *Plan*s any changes in your coverage.

American Recovery and Reinvestment Act (ARRA)

The American Recovery and Reinvestment Act of 2009 (ARRA) provides for premium reductions and additional election opportunities for health benefits under COBRA. The premium reduction applies to periods of health coverage beginning on or after February 17, 2009 **and lasts for the time period established by law** for those eligible for COBRA due to an involuntary termination period, as defined by the ARRA.